UNC Pharmacy Assistance Program (PAP)

INSTRUCTIONS
Requirements and Documents for Application

If you have questions about the PAP application or the **14 day Temporary PAP Benefit**, please call **(919) 966-7690.** A counselor is available, by phone, to help you **Monday - Friday 8 am- 4:30 pm**.

Instructions to Apply for Pharmacy Assistance:

A. Complete the PAP Application: Sign and date each page that requires a signature **and do not leave anything blank**. All applicable information is required. Please submit completed application with all required documents **within 5 business days of receipt for new patients (**14 days temporary benefits) and within **14 days for renewal applications**.

B. **Provide required documents (for patient and spouse or guardian if applicable) to show *Total Household Income*:**

- ☐ **Federal Tax Forms**: copy of 1040 tax forms submitted to IRS in current year
- ☐ **Bank Statements**: last 3 months of bank statements for all accounts; include all pages of each
- ☐ **Income from Social Security/Disability/Unemployment/Pension/Other Sources** (if received): 1 recent benefits statement or check stub
- ☐ **If Employed:**
  - Last 3 pay stubs from employer **OR** a letter from employer **(notarized or on company letterhead)** stating rate of pay, hours worked weekly, and pay frequency
  - For self-employment, provide 3 month ledger listing business income and expenses
- ☐ **If No Household Income:** Provide **Statement of Assistance (Appendix B)** showing financial support of household. Statement must have signature and date from person/organization who provides daily living expenses

For same day processing, please bring completed application and ALL required documents to a PAP counselor at the on-site locations listed below (counselors are available at on-site locations **Monday - Friday 8 am- 4 pm)**:

Modes of submission: By Fax to 1(866)-316-4138 OR

Mailing Address (MAIL ONLY)	**Same Day (ON-SITE ONLY)** Hillsborough, NC	**Same Day (ON-SITE ONLY)** Chapel Hill, NC
UNC Medication Assistance Program UNC Shared Services Center 4400 Emperor Blvd Durham, NC 27703	UNC Hospitals Hillsborough Outpatient Pharmacy 430 Waterstone Drive First Floor Hillsborough, NC 27278	UNC Hospitals Central Outpatient Pharmacy 101 Manning Dr Chapel Hill, NC 27514

Requirements for Pharmacy Assistance: To qualify for the full PAP Benefit, the patient must meet Eligibility Criteria and the PAP application approved.

Eligibility Criteria:

- **A.** North Carolina resident (Appendix A)
- **B.** No insurance that pays for prescription medicines
- **C.** Yearly household income 200% or less of the Federal Poverty Level (FPL)
  1. Provide documents to show monthly household income (patient and spouse)
  2. Provide total number of legal dependents living in household (including minor children)
- **D.** Prescription written by an approved provider presently working at a UNC affiliated entity

UNC Pharmacy Assistance Program
Application for Pharmacy Assistance

PATIENT FINANCIAL STATEMENT

Important: To be considered for financial assistance for medically necessary services, this confidential financial statement must be completed. To be considered complete, all questions must be answered, the form must be signed, and verification of your household income *before taxes* must be attached. Please send your most recent entire/complete Federal Tax Return and copies of all other income statements. If you do not file federal taxes, you must explain why and explain who is supporting you financially (use Statement of Assistance, Appendix B).

Patient Name:_____ Patient Medical Record #:_____

Social Security #_____ Date of Birth_____

Marital Status: ☐Single ☐Married

PATIENT/LEGAL GUARDIAN INFORMATION (for minors only, enter parent(s) or legally recognized guardian(s) information)

Last Name | First Name | M. I. | Social Security Number

Medical Record Number | Relationship to Patient (if patient is a minor) | Phone Number

Address | City | State | Zip | County

Employer Name | Employer Phone Number | Length of Employment

Business Address | Position/Job Title

☐ Spouse ☐ Parent

Patient's Spouse *or* Parent if Patient is a Minor | Medical Record # | Spouse's/Parent's Social Security Number

Spouse's/Parent's Employer | Length of Employment

Employer's Address | Employer's Phone Number | Position/Job Title

HOUSEHOLD: LEGAL DEPENDENTS FOR WHOM YOU PROVIDE FINANCIAL SUPPORT

First Name	Last Name	Medical Record Number (MR #)	Relationship to Patient	Birth date	Age

Bank name:_____ ☐ Checking ☐ Savings

Have you filed taxes in the past year? ☐ Yes ☐ No

- If yes, please include copy of federal tax forms submitted to IRS.

Have you applied for Medicaid in the last 6 months? ☐ Yes ☐ No

- If yes, please include denial letter. If no, please explain.

UNC Pharmacy Assistance Program

Monthly Household Income

(List amount of income received each month)

INCOME BEFORE TAXES	MONTHLY INCOME
Patient's income before taxes, or if patient is a minor child, list the income of parents (before taxes)	
Second job (if any)	
Spouse's Income (before taxes)	
Second job (if any)	
Farm/Business income	
Unemployment Compensation	
Worker's Compensation	
Retirement Pension	
Social Security	
Supplemental Social Security Income	
Disability Income	
VA Benefits	
Alimony	
Interest/Dividends	
Rental Property Income (received)	
Other Income Sources	
Total monthly income	**$**

I certify that the answers written above and any additional information and/or income/expenses that I have listed on a separate sheet are true to the best of my knowledge. I understand that fraudulent or misleading information will make me ineligible for any financial assistance. I authorize the release of any information needed to verify the information provided. I give my social security number voluntarily and have the permission to give the social security numbers of the others provided. The social security numbers may be used for the purpose of accurate identification, filing insurance claims, billing, collections and compliance with federal and state laws.

Patient's Additional Comments: _____

X _____ **X** _____

Patient (or Guarantor) Signature | Date of Signature

Appendix A

UNC Pharmacy Assistance Program

NORTH CAROLINA RESIDENCY

North Carolina Residency Definition: *To meet North Carolina state residency requirements, an individual must be domiciled in North Carolina with the intention to remain here permanently or for an indefinite period or show that he/she entered North Carolina to seek employment or with a job commitment. A person is domiciled in North Carolina if North Carolina is his/her fixed, established, or permanent place of residence with the intention to remain there permanently or for an indefinite period.*

Required Documentation: **To verify residency, provide one document from the categories listed below.**

a. A valid North Carolina drivers' license or other identification card issued by the North Carolina Division of Motor Vehicles
b. A current North Carolina rent, lease, or mortgage payment receipt, or current utility bill in the name of the applicant or the applicant's legal spouse, showing a North Carolina address.
c. A current North Carolina motor vehicle registration in the applicant's name and showing the applicant's current North Carolina address.
d. A document verifying that the applicant is employed in North Carolina.
e. One or more documents proving that the applicant's home in the applicant's prior state of residence has ended, such as closing of a bank account, termination of employment, or sale of a home.
f. The tax records of the applicant or the applicant's legal spouse, showing a current North Carolina address.
g. A document showing that the applicant has registered with a public or private employment service in North Carolina.
h. A document showing that the applicant has enrolled his children in a public or private school or a child care facility located in North Carolina.
i. A document showing that the applicant is receiving public assistance (such as Food Stamps) or other services which require proof of residence in North Carolina. Work First and Energy Assistance do not currently require proof of NC residency.
j. Records from a health department or non-UNC health care provider located in North Carolina which shows the applicant's current North Carolina address.
k. A current North Carolina voter registration card.
l. A document from the US Department of Veterans Affairs, US Military or the US Department of Homeland Security verifying the applicant's intent to live in North Carolina permanently or for an indefinite period of time, or that the applicant is residing in North Carolina to seek employment or has a job commitment.
m. Official North Carolina school records, signed by school officials, or diplomas issued by North Carolina schools (including secondary schools, colleges, universities, community colleges), verifying the applicant's intent to live in North Carolina permanently or for an indefinite period of time, or that the applicant is residing in North Carolina to seek employment or with a job commitment.
n. A document issued by the Mexican consular or other foreign consulate verifying the applicant's intent to live in North Carolina permanently or for an indefinite period of time, or that the applicant is residing in North Carolina to seek employment or has a job commitment.
o. A document showing that the applicant is living in a North Carolina homeless shelter

Appendix B

UNC Pharmacy Assistance Program

STATEMENT OF ASSISTANCE

_____

(Name of Patient)

Patient/Guarantor: If the patient has no income, please provide a *Statement of Assistance*, signed and dated, from the person who provides daily living expenses. The statement may be written below or provided as a letter of support.

I confirm the information provided above is true and complete.

Signature _____

(person who provides daily living expenses)

Relation to the patient _____

Date Signed _____

Appendix C

UNC Pharmacy Assistance Program

SIGNATURE WAIVER FORM

Thank you for your interest in applying for Medication Pharmacy Assistance Programs. These programs are a very important resource for patients in need of expensive medications. If you qualify for these programs, medications that are prescribed by your UNC provider may be financially assisted by independent patient assistance organizations or the drug manufacturer.

To allow our Medication Assistance Program (MAP) Specialists to apply on your behalf to independent patient assistance organizations, we must obtain your consent to share information about your medical condition, prescription(s), and income. By signing below, you also acknowledge your consent to allow the MAP team to serve as your advocate when applying for assistance.

If you have questions or concerns, please contact a MAP Specialist at (919) 957-5600.

PATIENT INFORMATION

Patient Name:_____ Medical Record Number: _____

Date of Birth:_____ Preferred Method of Contact: ☐ Phone ☐ Email

Address:_____ Preferred Phone: _____

City:_____ Alternate Phone: _____

State:_____ Zip:_____ E-mail: _____

PATIENT FINANCIAL INFORMATION

Number of people living in household who contribute to or are dependent on your household income: _____

Estimated Gross Household Income (numerical value required): $_____ ☐Yearly ☐Monthly

(Income must reflect amount for entire household.)

Please check all sources of income that apply:

☐ Salary/wages ☐Social Security ☐ Earnings from dividends

☐ Pension ☐ Disability ☐ Earnings from rental property

Start date: _____

CONSENT TO RELEASE INFORMATION

I give my permission for the MAP Specialists employed by UNC Health Care to do **both** of the following:

1. Release my information to independent patient assistance organizations to help me obtain medications prescribed by a UNC provider.
2. Serve as my advocate in seeking donated prescription medication for my use. To accomplish this goal, I authorize the MAP Specialists to sign my name on all appropriate pharmacy assistance program form(s) required by independent or manufacturer patient assistance programs.

This permission will be valid until it is withdrawn by me in writing.

Patient (or Guarantor) Signature:_____ Date: _____

Department of Pharmacy

Appendix D

UNC Pharmacy Assistance Program
LETTER OF AGREEMENT

Patient Name_____ Medical Record #: _____

Family Members for whom Pharmacy Assistance is requested:

1._____ 2. _____

3._____ 4._____

I agree to:

1. Cooperate fully with the Medication Assistance Program Specialist in making application to the UNC PAP and other assistance programs as requested. Failing to cooperate will result in termination of any assistance provided by the UNC PAP without notice.
2. Cooperate fully in applying to other assistance programs for which I may be eligible for benefits (e.g. Medicaid, Medicare, NC HMAP program, Sickle Cell program etc) within the timelines established.
3. Provide complete and accurate information. Providing misleading or inaccurate information will result in termination of any assistance provided by the UNC Ambulatory Pharmacy Care Network (APCN) without notice.
4. Participate in the Carolina Assessment of Medications Program (CAMP) Clinic if I am notified that I meet the enrollment criteria.
5. If approved by a manufacturer for free medication, I agree to obtain the medication from the manufacturer in accordance with their policies and procedures.

I agree to notify the Medication Assistance Program Specialist if and when:

1. North Carolina Medicaid benefits are received
2. I become eligible for Medicare or disability benefits
3. Any benefits are received that pay for prescription drugs (e.g., Medicare Part D, state AIDS Drug Assistance Program, commercial health insurance, etc.)
4. My income increases
5. I move and live out of state and am no longer a permanent resident of North Carolina.

I understand benefits provided through the UNC PAP are limited and subject to change without notice. Coverage of medicines:

1. Is limited to select medications, ostomy and diabetic supplies, on the PAP formulary and are subject to utilization management restrictions
2. Requires a prescription presented to a participating UNC outpatient pharmacy, written by a UNC provider, having seen the patient at a UNC affiliated entity.
3. Prescription refills must be ordered from the Shared Services Center (SSC) home delivery pharmacy, with select exceptions (consult a UNC pharmacy representative for details).

I understand and agree to cooperate with the terms of eligibility and requirements of the Pharmacy Assistance Program.

Patient (or Guarantor) Signature:_____ Date: _____